



Southwestern Forensic  
Associates, Inc.

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE: August 31, 2012**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic pain management sessions, 5x per week x 2 weeks.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR  
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with  
Certificate of Added Qualifications in Pain Management.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse  
determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

ODG are not met for the requested chronic pain management sessions, 5x per week x 2  
weeks.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. TDI referral information
2. Denial information, 7/18/12, 8/21/12
3. Preauthorization request, 7/13/12
4. Request for reconsideration, 7/27/12
5. Request for change of surgical facility, 8/10/12
6. Impairment Rating, 8/28/12
7. Office notes, 5/23/12 – 7/12/12
8. Physical Performance Evaluation, 5/15/12
9. H&P, 7/11/12

10. Treatment plan, 5/25/12
11. Psychological Assessment, 4/17/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This individual sustained an injury that was reported on xx/xx/xx. He has been diagnosed with carpal tunnel syndrome. Physical therapy, work hardening, and psychotherapy have been completed. Complicating factors include obesity. He is receiving medications including analgesics. Surgery was approved on 04/20/12. There is no indication that this surgery was performed.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

ODG require completion of other treatment modalities before considering a behavioral pain management program. This individual was approved for surgery, which should decrease the pain and increase functionality. ODG do not endorse a behavioral pain management program when more definitive treatment modalities are indicated.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- ☐ AHCPR-Agency for Healthcare Research & Quality Guidelines.
- ☐ DWC-Division of Workers' Compensation Policies or Guidelines.
- ☐ European Guidelines for Management of Chronic Low Back Pain.
- ☐ Interqual Criteria.
- ☐ Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- ☐ Mercy Center Consensus Conference Guidelines.
- ☐ Milliman Care Guidelines.
- ☒ ODG-Official Disability Guidelines & Treatment Guidelines
- ☐ Pressley Reed, The Medical Disability Advisor.
- ☐ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- ☐ Texas TACADA Guidelines.
- ☐ TMF Screening Criteria Manual.
- ☐ Peer reviewed national accepted medical literature (provide a description).
- ☐ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)